Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012066	A. BUILDING: _____ B. WING _____	06/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMOND COMMUNITY AMBULATORY CARE CENTE	2143 CALUMET AVENUE HAMMOND, IN 46394

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 33212 Facility Number: 012066 Type of Survey: State Licensure Off Site HFAP Accreditation Survey Date of HFAP On Site Survey - ASC full survey 6/13-14/2013 Date of ISDH off site review - - 10/04/2013 Reviewer/Surveyor Nancy Otten RN, PHNS Based on review of the 6/13-14/2013 HFAP Accreditation Survey Report, it has been determined that Hammond Ambulatory Community Care Center meets the requirements for Hospital Licensure in Indiana.	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE